

NOTICE OF INDEPENDENT REVIEW DETERMINATION

MDR Tracking Number: M2-04-0238-01
IRO Certificate Number: 5259

October 20, 2003

An independent review of the above-referenced case has been completed by a medical physician board certified in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

____ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ____.

Sincerely,

CLINICAL HISTORY

This is a lady who reportedly sustained a cervical and lumbar strain as well as a sprain of the shoulder and wrist. She was treated with oral medications and physical therapy. A trial of the requested device was initiated in April 2003. MRI noted a disc lesion and multiple level degenerative changes in the lumbar spine. Neurologist _____ suggested a home-based, self-directed exercise program emphasizing overall fitness and conditioning in addition to physical therapy. A pain management assessment suggested an epidural steroid in the face of

no resolution of the pain complaints. Dr. ____ completed the EMG and this was a normal study.

REQUESTED SERVICE(S)

Purchase RS4i Stimulator

DECISION

Deny (Endorse the pre-authorization determination).

RATIONALE/BASIS FOR DECISION

The primary treating physician failed to produce any competent, objective, and independently confirmable medical evidence demonstrating the efficacy of this device. The utilization curve is documented and there is no measurable improvement in this condition. This is from an April to September timeframe. Moreover, neither the pain management nor the neurologist, have even mentioned the use of such a device, or its efficacy. Has the use of oral analgesic been reduced? There is no data to indicate that is the case. Clearly there is no established positive result from this use of this device. Moreover, there is no clinical assessment made by the primary treating physician that would support the use let alone the purchase of this device. Lastly, this is a passive device and noting the date of injury, this claimant should be doing only those active modalities that enhance the rehabilitation of this injury.

The proposed device is not broadly accepted as the prevailing standard of care and is not recommended as medically necessary. Such passive modalities are indicated in the acute phase of care and their use must be time-limited. The Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include such modalities in the treatment of chronic pain greater than 6 weeks. Moreover, the efficacy of this type of device in the long-term patient has been studied repeatedly. As noted by Herman (Spine 1994 Mar 1;19(5):561) this treatment adds no apparent benefit. Lastly as described by Deyo (NEJM 1990 Jun 7(23):127-34) TENS is no more effective than placebo. The literature of blinded peer-reviewed studies does not support the efficacy of this device. The one study that was completed had a drop out rate of more than 50%, the appropriate methodologies were not reported and the overall efficacy was not a function of the device rather other external factors. This device does

not improve the situation, there is no identification of a decrease in medication use and the functionality of the claimant was not reported out.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 21st day of October, 2003.